women's health, but there is much more to be done. When the President spoke at the State of the Union, he mentioned an increase in funding for NIH. I was pleased to hear that, because I felt that we can have an increase in funding for cervical cancer, breast cancer, lung cancer, heart disease and diabetes. So Mr. Speaker, I will be introducing a bill suggesting the increased funding for those areas.

I would also call on the President to provide the health insurance for those over 10 million children who are without health insurance and the women who are without health insurance.

So, as we celebrate Women's History Month, let us be mindful of the need for increased funding for women's health.

WOMEN'S HISTORY MONTH

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Illinois (Mrs. BIGGERT) is recognized for 5 minutes.

Mrs. BIGGERT. Mr. Speaker, as the Republican co-chair of the Congressional Women's Caucus, I am very excited about what the 107th Congress promises for women, particularly in the area of health care. There have been great strides made in recent years in the area of women's health care, and I think that since the month of March is Women's History Month, I would like to thank my colleagues from the Congressional Women's Caucus who are taking the time to come down here this afternoon out of their busy schedules to discuss women's health issues.

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I think that a number of women will be discussing issues from eating disorders, breast cancer, and long-term care; and these are issues that affect all women, no matter their age, race, nationality or sexual orientation. I commend my colleagues for continually taking the lead on these important issues and look forward to continuing our work in the 107th Congress.

Mr. Speaker, I would like to, I think, look at one issue, but I cannot begin really without talking about that, for the first time in history, that the House Subcommittee on Health will be chaired by a women, the gentlewoman from Connecticut (Mrs. JOHNSON), our friend and colleague. That is very fitting when the issues that affect women have become so dramatic.

One of the issues that I would like to address in the area of women's health care that I care deeply about is long-term care. I think long-term care has long been called the sleeping giant of all U.S. social problems. This issue affects all Americans but particularly women for three reasons: Number 1 is we live longer; number 2, we are the ones who take care of our aging relatives; and, number 3, we are much more likely to retire with little or no pension savings. That makes us especially vulnerable to the high costs of long-term care.

The Census Bureau estimates that there are currently 34 million Americans aged 65 and older living in the United States. By 2030, that number is expected to more than double to 70 million, some 20 percent of the population. The fact that Americans are living longer and living more healthy lifestyles than at any time before should be celebrated. However, it does present a challenging public policy problem.

These numbers demonstrate the demand for long-term home or institutional care is going to grow exponentially. Neither the public nor the private sectors have adequately planned to meet the overwhelming future demand for long-term care services.

We must increase the public's awareness of the importance of preparing for long-term needs, as well as encourage individuals to save for their future, to invest in IRAs and mutual funds and to purchase long-term care insurance policies.

In addition, we must encourage employers to provide long-term care coverage as part of their employee benefit plans.

This is why I plan to reintroduce legislation that I introduced in the 106th Congress, the Live Long and Prosper Act, Long-term Care and Retirement Enhancement to address this issue.

There are several ways my bill addresses the problem facing long-term care.

First, my bill provides an above-the-line deduction, starting with 60 percent in 2002 and rising to 100 percent in 2006, for the cost of long-term care insurance premiums paid during a given year for the taxpayer, his or her spouse and dependents.

These provisions will make long-term care insurance more financially accessible, particularly for the young and those with lower incomes.

Second, my bill gives employers the option of providing long-term care insurance coverage as part of a cafeteria plan, in which employees are able to choose from a variety of medical care or other benefits, or flexible spending account, in which employees set aside pretax dollars for copayments or deductibles on insurance plans.

Third, my bill provides an additional personal exemption to the estimated 7 million Americans who provide custodial care to an elderly relative living in their home. The exemption was valued at $2,750 in 1999 and should help to alleviate some of the financial burdens involved with caring for a loved one at home.

These are just a few of the provisions of the bill, and they represent a market-based solution to an ever-growing demand for long-term care services and financing. But the financial incentives alone will not be enough to address the potential long-term care delivery and financial crisis.

Mr. Speaker, I urge all of my colleagues to take a look at that bill and to look at the women's health issues that are involved therein.

MANAGED CARE REFORM—MEDICAL NECESSITY

The SPEAKER pro tempore (Mr. GILCHREST). Under a previous order of the House, the gentleman from Texas (Mr. GREEN of Texas) is recognized for 5 minutes.

Mr. GREEN of Texas. Mr. Speaker, I would like to congratulate my colleagues, the congressional women, for making this effort today for special orders for women's health care. I would like to associate myself with their remarks, because everything they have said on a bipartisan basis is so important.

The reason I am here today, Mr. Speaker, is that the third time I have talked about the importance of managed care reform, real managed care reform, 3, 4 weeks ago I talked about the independent review process, and the accountability 2 weeks ago, and today I want to talk about medical necessity.

Every patient in America deserves to have important medical decisions made by his or her doctor, not by an HMO bureaucrat. Unfortunately, managed care personnel, who often have no substantial medical training, are determining what is medically necessary.

This practice endangers patients, threatens the sanctity of the doctor-patient relationship and undermines the foundation of our health care system.

Most managed care companies base treatment decisions on professional standards of medical necessity. But we often hear cases where HMO plans write their own standards into their contracts, and these standards often conflict with the patients' needs.

The case of Jones v. Kodak clearly demonstrates how a clever insurance health plan can keep patients from getting the needed medical care.

Mrs. Jones' employer provided health insurance coverage for in-patient substance abuse treatment. Unfortunately, the health plan determined that she did not qualify for this treatment. Even after an independent reviewer stated that the plan's criteria was too rigid and did not allow for tailoring of case management, Mrs. Jones was still denied treatment.

To add insult to injury, the courts stated that the health plan did not have to disclose its protocols or its rationale for making that decision.

A health plan's decision does not have to be based on sound medical science, standard practices or even basic logic. In fact, a health plan can